FOR OFFICE USE ONLY
Chart # _____
Account # _____
Taken By: _____
Prepared By: _____

York Medical Clinic, P.C.
family medicine
2114 N. Lincoln Ave., Ste. A
York, Nebraska 68467
(402) 362-5555

Date _____

PATIENT INFORMATION

Patient's Legal Name: _____ Male ____ Female ____

Nickname: _____ Date of Birth: ____/____/____ Age: _____

Single: _____ Married _____ Widowed: _____ Divorced: _____ Separated: _____

Social Security #: _____ - _____ - _____ Driver's License #: _____

Email Address: _____

Address: _____ Telephone: _____ Cell: _____

City, State, Zip Code: _____

Employer: _____ Work Telephone: _____

Race:
White (not Hispanic or Latino) ____
Black/African American (not Hispanic or Latino) ____
American Indian/Alaska Native ____
More than one race ____
Native Hawaiian ____
Other Pacific Islander ____
Asian ____

Ethnicity:
Hispanic or Latino ____
Not Hispanic ____

Preferred Language:
English ____
Spanish ____
American Sign Language ____
Czeh ____
Vietnamese ____
Other ____

PLEASE COMPLETE IF UNDER AGE 19

Father's Name: _____ Telephone: _____

Address: _____

Employer: _____ Work Telephone: _____

Mother's Name: _____ Telephone: _____

Address: _____

Employer: _____ Work Telephone: _____

PLEASE COMPLETE IF MARRIED

Name of Spouse: _____ Date of Birth: ____/____/____ Age: _____

Employer: _____ Work Telephone: _____

Maiden Name: _____

PERSON RESPONSIBLE FOR PAYMENT

Guarantor Name: _____ Date of Birth: ____/____/____ Age: _____

Employer: _____ Work Telephone: _____

Address: _____

City, State, Zip: _____ Telephone: _____

EMERGENCY CONTACT (not living with you)

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____ Telephone: _____

(OVER)

INSURANCE INFORMATION

Insurance Name: _____ ID #: _____

Insurance Billing Address: _____

Policy Holder: _____ Date of Birth: _____/_____/_____

Group #: _____ Policy Effective Date: _____

Type of Coverage: Single ____ Family ____ Other ____ (specify): _____

Do you have Medicare _____ #: _____ Effective Date: _____

Part A _____ Part B _____

Do you have Nebraska Medicaid _____ #: _____

Is Todays Visit Work Comp Related _____

ASSIGNMENT OF BENEFITS

I/We assign and authorize direct payment to York Medical Clinic, P.C. all insurance benefits to which I/we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits from settlements or awarded in judgment for any personal injuries caused by a third party.

I understand if my insurance carrier pays only a portion of York Medical Clinic's bill, the remaining portion is my responsibility. All unpaid patient balances over 60 days outstanding will be subject to late charges at 16% per annum.

I further authorize York Medical Clinic, P.C. to keep my signature on file and to bill future charges to my insurance carrier. A photocopy of this assignment shall be as valid as the original.

Name of Insured: _____

Social Security Number: _____ Birth Date: _____

Person(s) covered under this policy include(s):

NAME	BIRTH DATE	SOCIAL SECURITY NUMBER

I authorize the release of any medical or other information necessary to process this claim.

I understand that I am personally responsible for all charges whether covered by insurance or not.

_____ _____

Signature-Patient Date

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative Relationship: _____

(parent, guardian, power of attorney)

I hereby certify that I have legal authority under applicable law to make this request in behalf of the patient identified above.

_____ _____

Signature of Personal Representative Date

_____ _____

Signature-Clinic Representative Date

York Medical Clinic, P.C.
family medicine

New Patient Health History

Name:_____ **Date:**_____

Date of Birth:_____ **Age:**_____ **Marital Status:** M S W D **Veteran:** YES NO

Health History

Yes	No	Condition	Explain
		Alcoholism/Chemical Dependency	
		Anemia	
		Arthritis/Gout	
		Asthma	
		Bleeding Disorders	
		Breast Lump(s)	
		Cancer(s)	
		Chicken Pox	
		COPD/Emphysema	
		Depression or Suicide Attempts	
		Diabetes	Last A1c:
		Ear/Sinus Problems	
		Epilepsy	
		Gastrointestinal/Stomach Problems	
		Heart Disease or Pacemaker	
		Hepatitis (A, B or C)	
		High Cholesterol	
		High Blood Pressure	
		Kidney Disease	
		Migraine Headaches	
		Multiple Sclerosis	
		Pneumonia	
		Prostrate Problems	
		Psychiatric or Mental Health Care	
		Rheumatic Fever	
		Sexually Transmitted Diseases	
		Sleep Disorders or CPAP Use	
		Stroke	
		Thyroid Problems	
		Tuberculosis	
		Vaginal Infections	
		Other Chronic Disease:	

Allergies (medications, food, latex or environmental)	Reaction

Health Habits

	Never Use	Daily Use (indicate amount)	Some Days (indicate how often)	Formerly/Past Use
Caffeine				
Tobacco				
Drugs				
Alcohol				

Immunizations

Have you ever had any of these vaccines? If yes, indicate what year given.

Pneumonia:_____ Tetanus:_____ Shingles:_____

Prevnar 13:_____ Last Flu Shot:_____ Other:_____

Current Medications	Dose and Frequency

Serious Injuries / Illnesses / Surgeries / Hospitalizations	Year and Location

Preventative Health History	Year and Location
Mammogram	
Colon Cancer Screening (Colonoscopy, ColoGuard, Fecal Cards)	
PAP (cervical cancer screening)	
Bone Density Testing (Dexa Scan)	
Last Eye Exam	

Family History

Relation	Age at Death	Cause of Death
Father		
Mother		
Brother(s)		
Sister(s)		

	Father	Fathers Father	Fathers Mother	Mother	Mothers Father	Mothers Mother	Siblings	Children
Asthma	❑	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
Degenerative Joint Disease	❑	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑
Lung Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑	❑

Emergency Contact Person:

_____

Emergency Contact Phone:

_____

F1.9

Practice: York Medical Clinic, P.C.
Address: 2114 N Lincoln Ave, Ste. A, York, NE 68467
Privacy Official: Administrator
Telephone: 402-362-5555

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form authorizes York Medical Clinic, P.C. (YMC) to release your Protected Health Information. Please complete this form if you want YMC to give your Protected Health Information to another person, such as your spouse or employer. "Protected Health Information" (PHI) is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services. Please refer to our Notice of Privacy Practices for examples of when **YMC** does not need your authorization to release your PHI. Please print clearly.

SECTION A: Individual authorizing release of PHI

YOUR NAME_____ **DOB#** _____

YOUR TELEPHONE NUMBER: (Day) _____ (Cell) _____

YOUR ADDRESS: _____
Street Apartment #

_____
City State Zip Code

SECTION B: Description of authorization

I hereby authorize York Medical Clinic, P.C. (YMC) to release my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, billing statements, Explanation of Benefits, laboratory reports, pathology reports, radiology/ultrasound records and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

This authorization applies to ALL PHI, unless you specify conditions or limitations here:

_____

SECTION C: Persons authorized to received my PHI

Please tell us who you are authorizing to receive your PHI by completing the table on the next page. Use the table to authorize family members or other individuals to receive your PHI (Example: spouse, friend, and attorney).

- The "Start Date" is the date this authorization will begin.
- The "End Date" is the date this authorization will end. If you do not want this authorization to end on a specific date, leave the "End Date" box blank. This authorization will remain valid until you notify us of an "End Date".

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TABLE 1: Family Members or Other Individuals Authorized to Receive Your PHI

Name of Person to Receive PHI	Person's Relationship to You	Address (City, State, ZIP Code)	Telephone Number	Start Date	End Date

Authorized Information will be used and/or disclosed for the following purposes:

- ☐ At the request of the individual (check box if applicable)
- ☐ Other (Please list each purpose of the use(s) or disclosure(s) in the space provided.):

_____

_____

SECTION D: Terms and conditions of this authorization

I understand that once released to the person(s) authorized above, my PHI is no longer protected by the federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization, unless revoked earlier, this authorization will end on the date specified above.

SECTION E: Your Signature

Signature of Individual: _____

Date_____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to the member (check one of the following):

- ☐ Parent
- ☐ Legal Guardian
- ☐ Power of Attorney